


Essay

Christian Ethical Boundaries of Suicide Prevention

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Abstract: In Western countries the general rule is that caregivers do everything possible to prevent suicide. The aim of this essay is to critically reflect on that position along three questions: is there an unconditional obligation to live, how far does the duty reach to safeguard life, and how does one deal with the tension between suicide prevention and euthanasia? The study material consists of Christian theological and ethical literature and relevant legislation, while the method is a religious ethical reflection, clarified by means of a case study. We consider suicide as an expression of an existential search for meaning and interwoven with psychiatric problems. After discussing the three ethical arguments against suicide, we conclude that the inviolability of life is a generally recognized and fundamental value, but that there is no unconditional obligation to live. Nevertheless, there is a legal duty to safeguard life. In practice however, restriction of freedom and coercion are counterproductive in the search for meaning and require a proportional assessment between inviolability of life and autonomy. Finally, the legal possibility of euthanasia in mental suffering or medically assisted suicide brings caregivers in a confusing situation. Good companionship of the euthanasia request may help finding a new life perspective and hence may contribute to suicide prevention.

Keywords: suicide; prevention; euthanasia; mental suffering; meaning; inviolability; autonomy; restriction of freedom; coercion

1. Introduction

Suicide is one of the leading causes of death in our society and is often associated with psychiatric problems ([American Foundation for Suicide Prevention 2015](#)). Many people, especially caregivers, are regularly confronted with people with psychiatric problems who have suicidal ideations, attempt or enact suicide. We understand caregivers as professional caregivers of various professional groups working in mental healthcare. The general rule is that these caregivers must do everything in their power to prevent enactment. This position is based on the traditional, philosophical and religious rejection of suicide and is anchored in the laws of Western countries that oblige caregivers to prevent suicide.

The aim of the present essay is to reflect critically on this mainstream position that condemns suicide and obliges caregivers to prevent suicide. The reflection is built around three questions. First, we ask whether the traditional rejection of suicide still holds true. Are exceptions accepted in the context of contemporary society and mental healthcare? Is there an unconditional obligation to live? The second question is whether the general rule that caregivers must do everything they can to prevent suicide is still valid. How far can measures go in restricting freedom to protect life? Are there limits in the context of contemporary society and mental healthcare? How far does the duty reach to safeguard life? Finally, the third question is completely new and only exists in countries with a legal regulation of euthanasia in mental suffering. How can caregivers combine the prevention of suicide and the possibility of euthanasia or assisted suicide by people with psychiatric problems? How to deal with the tension between suicide prevention and euthanasia?

The following case makes these questions more concrete.

Marie is 40 years old, a religious woman, teacher, married and mother of three teenagers. She is voluntarily admitted to a psychiatric hospital because she suffers from depression. Three years ago, she was admitted for the same reason and successfully treated with medication. Now the situation seems more serious. She behaves apathetically and neglects herself. She feels guilty and thinks she can no longer cope with her work, neglects her husband and children and would rather die. She is hopeless and does not want to live like that anymore. She wants to be free of this mental suffering and sees no other solution than a flight to heaven. It is her firm belief that she will find peace in heaven in the bliss of God's presence. She flees the hospital and is apprehended by police. The threat of suicide is increasing. Does Marie have an unconditional obligation to live under these circumstances? Caregivers put her under permanent observation with almost complete lack of privacy and protracted periods of seclusion. To what extent should they restrict her freedom to prevent suicide? Moreover, in this situation Marie could make a request for euthanasia. How can caregivers deal with this question while they prevent her from dying by suicide?

2. Materials and Methods

This contribution is an essay. The material consists primarily of theological, ethical and legal literature and the method is ethical. It is not grounded on systematic empirical research but on a thorough ethical analysis of practices. The first and second questions refer to Christian theological and ethical literature on the question whether suicide can be legitimated, respectively how restriction of freedom and coercion can be justified.

Secondly, the essay is based on legislation. The second and third questions refer to the legal duty to assist people in danger and to the legal possibility to perform euthanasia. Since legislation is to some extent different in all countries, we must limit ourselves to one country. Hence, we refer to the Belgian legislation because Belgium is one of the few countries with a euthanasia law that is applicable to mental suffering in a non-terminal situation, and because we know well the practice of this legislation.

Finally, this essay is founded on Christian ethical reflection. This is constitutive for our ethical methodology and determines our way of thinking and the conclusions we draw, which is by no means neutral or value-free. More specifically, we reflect from a relational approach to ethics that is based on Christian personalism and proportionalism (Hoose 1987; Selling 1988). This means that the ethical standard is the well-being or good life of the human person in his or her relation to others and the environment, and that this good life is concretized in a proportional or reasonable relation of the values that are at stake.

3. Results and Discussion

The results and discussion of our essay are structured along the three questions: is there an unconditional obligation to live, how far does the duty reach to safeguard life and how to deal with the tension between suicide prevention and euthanasia? Before we tackle these questions, we clarify our view on suicide. This vision partly determines our reflection and is based on a Christian ethical point of view.

3.1. Ethical View on Suicide

In our view, suicide is fundamentally an expression of a person's existential quest for meaning. Existential refers to people's existence or life. People face life in a certain way and their aim is to find and experience meaning in life (Van Knippenberg 2002). Certainly, this is a challenge for many people with psychiatric problems. They question, in an outspoken or unspoken way, the meaning of their life. Why has this mental suffering befallen me? What have I done wrong? What have I made of my life? Who am I in fact? How can I live on with this mental suffering? How can I live with others? What is my future? When the meaning of life is lost, life itself can become an unbearable and hopeless

suffering. Such suffering demoralizes people and makes them feel desperate. To get rid of their agony, they sometimes see no other way of escape than by dying by suicide.

At the same time, suicide is interwoven with a person's psychiatric problems directly or indirectly. Indeed, seeking and experiencing the meaning of life is also influenced by people's psychological functioning. Among people with psychiatric problems, the disorder may play an important role in their interpretation and experience of the meaning of life (Swinton 2001).

In some situations, they may suffer directly from their psychiatric problems. The psychiatric problems can have an impact to such a degree that they lose insight in their illness and life conditions. They can no longer detach themselves from their psychiatric problems. As such, they are sometimes driven to die by suicide by an internal compulsion related to their pathology. In these situations, they have not sufficient decision-making capacity and, hence, suicide is not a voluntary and deliberate choice of death over life. Decision-making capacity is a gradual concept that indicates whether someone is at a given moment able to make a specific decision in a voluntary and deliberate way (Widdershoven et al. 2017).

In other situations, people may suffer indirectly under their psychiatric problems. This means that they suffer in an indirect way under the awareness and circumstances associated with that disorder. In that case, people with psychiatric problems retain to a certain degree insight in their illness and life conditions. Although their pathology may distort and narrow their experience of reality, they can take some distance from their problems. They can become aware of the gravity of their existential crisis and ask probing questions about the meaning of life. They might feel demoralized and desperate and may lose hope and perspective on life (Eneman and Sabbe 2006). That is how it is with Marie, who feels so guilty and sees no way out, other than a flight into heaven. Sometimes, even caregivers might believe that certain people find themselves in an almost desperate situation. For most people with psychiatric problems, the choice of suicide is strongly influenced by their pathology and is therefore less competent, voluntary and deliberate. However, some of them make a balance of their life and come to a more competent, voluntary and deliberate choice of suicide. Psychiatric problems mostly lead to a diminished decision-making capacity to make a voluntary and deliberate choice to die by suicide, but certainly not always and not completely.

3.2. *Is There an Unconditional Obligation to Live?*

With this ethical view on suicide as an expression of an existential search for meaning and interwoven with psychiatric problems, we can now ask the question whether there is unconditional obligation to live. There is a large societal consensus about the inviolability of life. This is founded in the Western philosophical and religious tradition, specifically the thinking of Aristotle and Thomas Aquinas (Aquinas n.d.). In this tradition there are three ethical arguments against suicide: it is an offense of man against him- or herself, against society and against God.

3.2.1. *Offense against One's Own Life*

In the first place, suicide is an offense against one's own life because people have a natural tendency toward self-preservation (Aquinas n.d.). People naturally want to live and strive to preserve their lives. In the philosophical and religious tradition, a natural tendency is a human inclination to do good. With their reason people can derive from nature what is good. Human reason teaches that life is a good and death an evil. Consequently, self-preservation of life belongs to natural law. Preservation of life, therefore, is an ethical good, while suicide is an evil.

This argumentation, however, is debatable (Kuitert 1994; Van der Ven 2010). The first reason is that it contains a circular argument: there is an obligation to live because life is a good. Hence, it is already assumed that life is a good, and death an evil. This assumption was generally accepted in the traditional worldview of philosophy and religion. And today also, the vast majority of people have a fundamental experience that life is a good that they cherish and want to preserve. But whoever today does not share the assumption or fundamental experience that life is a good does not come to

assuming the obligation to live either. The second reason is that especially people with psychiatric problems in the context of contemporary society and mental healthcare may experience their suffering as so painful, unbearable and hopeless that they no longer experience life as a good. This is also the case with Marie, for whom life has become a hell from which she wants to be redeemed by fleeing to heaven. For many people with psychiatric problems, the argument loses its validity. Consequently, there is no longer an unconditional obligation to live. The inviolability of life, however, remains a generally acknowledged and fundamental value.

3.2.2. Offense against Society

A second argument is that suicide is a crime against society ([Aquinas n.d.](#)). The reason is that society counts on the contribution of all its members to build the community. Without the input of the individuals who strive for the common good, no community is possible. People who die by suicide cause damage to society because society can no longer count on their contribution to building community.

Today this argument is more difficult to understand ([Kuitert 1994](#)). We attach much greater importance to the individual and we have an aversion to totalitarian regimes in which community comes first. People with psychiatric problems who experience that society no longer values them, will not consider suicide to be an offense against society. We can give this argument a more contemporary content by considering society as the social network in which people live. For those who are connected to family, neighbors, friends and colleagues, suicide is usually an offense against them. Marie networks with her husband, her children and many people at school. This solidarity implies that she bears responsibility for these people, and that she must take them into account in her suicidal thoughts. Hence, the traditional argument is reduced to responsibility towards significant persons. This new argument of responsibility has more validity, but is nevertheless limited to people who experience solidarity with those close to them. This is often not the case with people with psychiatric problems. Consequently, this argument cannot lead to an unconditional obligation to live, but to a generally acknowledged and fundamental value of life in solidarity and with responsibility for others.

3.2.3. Offense against God

Suicide finally also is an offense against God ([Aquinas n.d.](#)). Today this argument is only binding for those who believe in God. It consists of two sub-arguments. A first sub-argument is that God is the Creator of life. Out of love, God created human beings in his image and likeness. When people cause damage to life or end life, they also damage the Creator. Life is a gift from God. At the same time God is also the Lord of life and He is the owner of life. Here we can discern a certain tension: life is a gift, but God remains the owner of the gift ([Kuitert 1994](#); [Van der Ven 2010](#)). People usually do not experience a gift that way. They see themselves with the appropriate gratitude as the new owner of the gift, and if not, it was not a real gift. Regarding creation, that tension is usually dealt with in such a way that the ownership prevails on the gift. As a result, life as a gift is put in the background and the ownership of God comes to the forefront. Depending on their image of God, people will regret that the ownership over life has priority over the gift character of life. Marie is a faithful woman and the question is how much she experiences life as a gift from God and how much she sees God as the owner of her life.

A second sub-argument for suicide as an offense against God is the fifth commandment 'you shall not kill/murder'. Usually the translation 'do not kill' is used, but in many recent translations, 'you shall not murder' is preferred because exegetes and translators find this a more correct translation ([NRSV n.d.](#), Ex 20, 13). This difference in translation is of great importance for the ethical reflection. 'Kill' only describes the act of the ending of people's lives while 'murder' adds something to this action, namely that this killing is not justified. The unjustified character is then determined by the intention or the motives, and by the circumstances or context. This distinction is also found in the Christian tradition ([Gula 1989](#)). It has been applied in the case of killing in self-defense, of killing in the just war

and of killing of guilty persons. In all these cases, not only the action itself is considered, but also the intention and the circumstances. This way of ethical reasoning can also be applied to suicide. With a certain intention and in specific circumstances, killing oneself could be justified. For people with psychiatric problems, it is possible that in their intention and in those circumstances, they do not regard the ending of life as an unjustified killing. In the case of Marie, the question is what her intention really is and how unbearable life is with the psychiatric problems she is facing. Notwithstanding, the command not to kill or not to murder is central to Christian faith. Even though there are exceptions that justify killing, the inviolability of life remains a fundamental Christian value. Christian inspired values, however, are only binding on people who accept Christian faith.

3.3. *How Far Does the Duty Reach to Safeguard Life?*

Although they may not be applicable in the specific circumstances of people with psychiatric problems, in general the three traditional arguments against suicide retain their meaning and validity. They lie at the basis of the general rule that caregivers by all available means must try to prevent suicide. This ethical standpoint is legally anchored in the principle of culpable negligence. This is the guilty failure to help someone who is in great danger.

3.3.1. Culpable Negligence

In fact, suicide is not punishable under Belgian law. There is, however, a duty to assist in protecting the lives of people who want to die by suicide. This duty was formulated in a negative way in the general legal principle of culpable negligence (originally in Dutch: ‘Schuldig verzuim’). According to law, people commit culpable negligence when they fail to assist a person in great danger. This general principle is applicable to all situations where people are in great danger, hence also to people who want to die by suicide. An important condition is that the person can offer help without danger to him- or herself or to others. The obligation to assist is always applicable, unless the person has not established the danger him- or herself, or based on the circumstances, could believe that the request was not clear, or the danger not imminent ([Strafwetboek n.d.](#)).

In mental healthcare, prevention of suicide is undoubtedly a serious legal duty. Caregivers must make every effort to prevent suicide. Permanent observation with almost complete absence of privacy and protracted periods of seclusion in the case of Marie fits completely within a policy of avoidance of culpable negligence. If the caregivers were not to do this, and Marie dies by suicide, they would have to legally justify themselves and prove that they have taken all possible due care and protective measures to prevent suicide. The legal principle of culpable negligence can lead caregivers to use far-reaching measures to restrict freedom. This creates new problems.

3.3.2. Limits to Freedom Restriction

The caregivers may take freedom-restricting measures to prevent suicide. They must first consult with the person with psychiatric problems, according to patient’s right to informed consent ([Wet Rechten Patient 2002](#)). The person may agree and may give explicit or implicit consent, or not. The latter puts caregivers in a difficult position. Either they do not apply the restriction of freedom, which might amount to committing culpable negligence, or they enforce the restriction of freedom as a coercive measure, against the will of the suicidal person. Examples are involuntary hospitalization, forced administration of psychopharmacological agents, confinement in a seclusion room, possibly in combination with physical restraint. To protect Marie from dying by suicide, the caregivers proceeded to extended periods of seclusion.

The use of coercion creates an existential problem. In our view on suicide we highlighted suicide from the psychological and existential dimension of life. The will to die by suicide has to a large extent to do with meaning in life that may or may not be experienced. The freedom to search for meaning is a necessary condition to find and make meaning in life. Coercive measures restrict that freedom and create a field of tension: on the one hand, caregivers limit the freedom to protect life,

and on the other hand, they must give freedom as a necessary condition to experience meaning. Coercive measures therefore work counterproductively in the process of finding and making meaning. This counterproductive situation is also present in the case of Marie. It is almost impossible for them to overcome her hopelessness and to discover new meaning in her life when she is persistently watched, has insufficient privacy, and stays longer and longer in the seclusion room. Mostly, restriction of freedom increases feelings of hopelessness and loss of meaning in life.

Restrictions of freedom and coercive measures are also a fundamental ethical problem because autonomy is an important value in contemporary society. Caregivers therefore must apply these measures with due care and responsibility. To assess which measures are justified, they can rely on the principle of proportionality (Liégeois 2016). This means that there must be a reasonable or proportional relationship between the intrusive character of the freedom-restricting and coercive measure and the seriousness of the threat to life. From an ethical perspective, there is a tension between the value of autonomy and the value of inviolability of life. Proportionality implies that caregivers look for alternatives that can prevent the threat of life with less coercion. Is more intensive care with greater support of Marie and lesser restriction of her freedom a feasible alternative? Even if coercive measures are unavoidable, proportionality imposes on caregivers to exercise freedom-restrictive and coercive measures no more intensive and no longer than necessary. Could Marie also be adequately protected with less drastic restrictions of freedom? Are observation and seclusion really necessary as measures for the protection of Marie? Do the persistent character of that observation and the extended periods of seclusion really last no longer than necessary for her protection? The principle of proportionality does not offer a ready-made answer, rather it is a guideline for caregivers to make a balance between the values of autonomy and inviolability, and to take and justify the appropriate protective measures.

3.4. *How to Deal with the Tension between Suicide Prevention and Euthanasia?*

An even greater challenge is the possibility of euthanasia and medically assisted suicide to persons with unbearable mental suffering, albeit in the countries with such legislation and under the legal provisions. This brings the caregivers into the next field of tension: according to the legal principle of culpable negligence they must do everything in their power to prevent any suicide. If however, the person with psychiatric problems requests euthanasia or medically assisted suicide, they can cooperate in the enactment of that euthanasia or suicide if the legal requirements are met. This creates a confusing situation for caregivers.

3.4.1. Legal Requirements

We will discuss the Belgian situation because there are only a few countries where euthanasia or assisted suicide by people with unbearable mental suffering in a non-terminal situation is no longer punishable. Belgian law is limited to euthanasia, but in the practice of care euthanasia and assisted suicide by a physician are equated, if the physician respects the legal provisions. Even though there is no explicit legal regulation, assisted suicide by a physician, also called medically assisted suicide, is in practice no longer punishable in Belgium, if the legal requirements for euthanasia are met (Vandenberghe 2017).

The Belgian law includes the possibility of euthanasia in case of unbearable mental suffering in a non-terminal situation at current request. Three material requirements in respect to the person's condition are fundamental. According to law, the person must have attained adulthood or be an emancipated minor, and be legally competent and conscious at the moment of making the request. Second, the request must be voluntary, well-considered, and repeated, and it must not be the result of any external pressure. Third, the person must be in a medically hopeless condition of persistent and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident (Wet Euthanasie 2002).

There are also formal requirements with respect to the physician and the person requesting euthanasia. According to law, the physician must inform the person about his or her health condition and

discuss his or her request and the possible treatments. Together, the physician and the person requesting euthanasia must come to the conviction that there is no reasonable alternative to the person's condition than the performance of euthanasia. The physician must consult another physician, discuss the request with the nursing staff, and ensure that the person is given the opportunity of conferring with relatives and other persons. The person must formulate his or her current request in writing. If the person is not expected to imminently die, as in the case of unbearable mental suffering, the physician additionally must consult a psychiatrist and allow at least one month between the request for and the performance of euthanasia. Even if the person requesting euthanasia meets all legal requirements, the physician and any other caregiver cannot be obliged to cooperate in euthanasia ([Wet Euthanasie 2002](#)).

3.4.2. Confusing Situation

This legislation places caregivers in a confusing situation. This is also the case with Marie. The caregivers do their utmost to prevent Marie from dying by suicide, including the necessary restrictions of freedom and coercive measures. If, however, Marie were to ask for euthanasia because of unbearable mental suffering and would comply with the legal requirements, the caregivers would be allowed to help her with medically assisted suicide. The question, however, is whether Marie meets all the requirements prescribed by the law. To this end, we would need much more detailed information about her life conditions. The caregivers should also go a long way in clarifying the euthanasia request and in accompanying Marie in her search for a new life perspective.

We emphasize, however, that not everyone who wants to die by suicide meets the requirements for euthanasia in mental suffering. There are three fundamental requirements that relate to the mental competence of the person in formulating the request, to the medical hopeless condition of unbearable suffering that cannot be alleviated, and to the finding that there is no reasonable alternative to euthanasia. In addition, several organizations advocate stricter enforcement of due care requirements specifically addressing the mainly mental suffering in non-terminal situations to replace those presently applicable that primarily focus on the preponderantly somatic suffering in terminal situations. ([Dutch Association for Psychiatry 2009](#); [Flemish Association for Psychiatry 2017](#)). This implies that the group of people eligible for euthanasia in mental suffering is more limited than the group of people who want to die by suicide.

Testimonies of patients and family members show that there is a big paradox in accompanying a person with a euthanasia request ([Callebert et al. 2012](#)). By taking seriously the request within a caring companionship, people sometimes find a new perspective on life. Furthermore, people who receive approval of their euthanasia request sometimes no longer ask for the execution of euthanasia. In both cases, the experience that their mental suffering is acknowledged and the knowledge that there is a way out of their suffering, makes a new life perspective possible and the suffering less unbearable. It is remarkable how in the case of euthanasia in mental suffering, the quality of the accompaniment process influences the outcome of the process.

If we return to the link between suicide prevention and euthanasia, we can affirm that the legal requirements for euthanasia cannot be considered as exceptions to the prevention of suicide. It is not permitted that caregivers stop their efforts to prevent suicide if they think that the requirements for euthanasia in mental suffering are likely to be met. The law on euthanasia and the legal principle of culpable negligence are clearly different legal regulations that are not related to each other. There is no exception to culpable negligence other than uncertainty about the danger.

Consequently, the field of tension in the practice of healthcare remains, while the legislator does not give an explicit answer on how caregivers can deal with this. The caregivers may implicitly derive an answer from the legislation. On the one hand, the important rule is that they do everything possible to prevent suicide based on the legal principle of culpable negligence. On the other hand, they can apply medically assisted suicide or euthanasia to that limited group of people who explicitly request euthanasia and comply with all relevant legal requirements. Nevertheless, a lot of uncertainty and confusion remains for caregivers. It would be better for the legislator to create a broader framework in

which the prevention of suicide and euthanasia or medically assisted suicide in mental suffering are considered in their mutual relationship.

4. Conclusions

This essay is an ethical reflection on the boundaries of suicide prevention. In our ethical view, we consider suicide as an expression of an existential search for meaning and interwoven with psychiatric problems. In the Christian tradition there are three arguments against suicide: it is an offense against life, against society, and against God. After discussion of these arguments we conclude that the inviolability of life is a generally recognized and fundamental value, but that there is no unconditional obligation to live. Nevertheless, there is a legal duty to assist in safeguarding life. This may lead to freedom-restrictive and coercive measures that pose a real problem. We see these measures as counterproductive in the search for meaning and hence propose a proportional balance between the restriction of freedom and the inviolability of life. Finally, the legal possibility of euthanasia in mental suffering or medically assisted suicide puts caregivers in a confusing situation regarding their duty of preventing suicide. Good companionship, however, can assist a person with a euthanasia request in finding a new life perspective, and thus can contribute to suicide prevention.

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